Subcommittee on Africa, Global Human Rights and International Operations
Prepared Statement of Rep. Christopher H. Smith, Chairman

Malaria and TB: Implementing Proven Treatment and Eradication Methods

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The Subcommittee will come to order. I am pleased to convene this hearing of the Subcommittee on Africa, Global Human Rights and International Operations. Today we will be examining the U.S. government's efforts to combat two killer diseases, Malaria and Tuberculosis, which are ravaging the developing world.

The bad news is sobering. One-third of the world is infected with the TB bacterium, and it is the leading cause of death for people with HIV/AIDS. There is a TB explosion in Africa today due to the AIDS pandemic, and sub-Saharan Africa is staggering under the burden of the highest TB rates in the world. Tuberculosis accelerates the progression of HIV, making people sicker sooner.

Similarly, Malaria is the number one killer of children and pregnant women in Africa, and one of the top killers in Asia and South America. An estimated 600 million people contract malaria each year, resulting in between one and two million deaths, and almost 3,000 children die from the disease *every day*. Infection rates for malaria dwarf that of HIV/AIDS, and the vast majority of malaria patients are poor pregnant women and children under five years old, who die within days.

Believe me, malaria is a dreadful disease. I saw my own father, a combat veteran who contracted the disease in New Guinea during World War II, struggle under its effects for years.

The good news, however, is that both diseases are ***preventable*** and ***curable***. "DOTS," which stands for "Directly Observed Treatment, Short-Course," is the WHO-recommended strategy for the detection and cure of standard TB. Its key elements include political commitment to detect, treat, and monitor infected individuals, which includes a standardized treatment regimen of six to eight months. A six-month course of anti-TB drugs costs only $12 and can produce cure rates of up to 95% even in the poorest countries. But despite its low cost and proven success, DOTS is reaching only slightly over one-third of people sick with infectious TB.

Malaria, likewise, is inexpensive and easy to treat, and can be controlled with proven successful methods combining use of small, environmentally safe amounts of insecticide in homes and buildings; distribution of insecticide-treated bed nets; treatment with drug regimens; and focus on vulnerable populations, such as pregnant women.

Malaria has largely been eradicated in the developed world, and a few countries which have employed this comprehensive eradication and treatment strategy have experienced quick, dramatic reductions in infection rates. In Zambia's copperbelt, for instance, a privately-funded malaria control program begun in 2000, which included insecticide spraying, saw a decline of

malaria cases of 50% in just one season. Today malaria cases are down 80%, and the number of deaths down even further with the introduction of newer and better drugs. Malaria has been largely eradicated in northern regions of South Africa, thanks to a similar campaign funded by South African private donors and the Global Fund.

The purpose of this hearing today is to examine our own foreign assistance efforts to eradicate these two scourges and mitigate the suffering and deaths of millions of women and children. And frankly, I am concerned. In the seven years since the UN Roll Back Malaria Partnership first set its goal to halve malaria rates, rates have instead increased steadily by ten percent. As the rates of HIV/AIDS have grown, TB rates are skyrocketing. The U.S. and global response to HIV/AIDS is heartening, but not enough attention is being paid to addressing TB and Malaria.

The President's Emergency Plan for AIDS Relief approved by the 108th Congress included authorization for the U.S. government to treat those infected with malaria and TB. However, other than those also infected with HIV, none of these funds has been spent for treatment of a single person infected with malaria or tuberculosis.

USAID's Child Survival and Health programs spend approximately $80 million respectively for malaria and TB programs annually. For FY 06, the Administration is requesting $139 million, a *decrease* of $30 million over the previous year's level, primarily to strengthen TB and malaria prevention and control programs at the country level. Budget request documents state that malaria treatment programs will focus on expanding access to insecticide treated bed nets, intermittent treatment for pregnant women, and the roll-out of new combination drug therapies. TB programs which expand and strengthen the DOTS strategy at the country-level are the focus of USAID's tuberculosis program.

My response to these proposed programs is that it appears we are doing more of the same – at even reduced funding levels. But more of the same is not going to roll back malaria, or stop the escalating rates of TB. In our HIV/AIDS strategy, we spend approximately one-third of funds for treatment programs. Why are we spending only seven percent of our malaria program funds on direct interventions, when so many lives could be saved by getting the right drugs and the right tools to the most vulnerable?

I look forward to the testimonies of our expert witnesses both from the government and from the private sector. I hope to hear good news stories of how we are strategically targeting areas where we can have an impact; how we are documenting that our dollars are producing real results; and how we are saving lives.